STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155156	A. BUILDING 01 B. WING	07/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS AT MICHIGAN CITY	1101 E COOLSPRING AVE MICHIGAN CITY, IN46360

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 07/25/11 Facility Number: 000076 Provider Number: 155156 AIM Number: 100271060 Surveyor: Richard D. Schade, Life Safety Code Specialist At this Life Safety Code survey, Arbors at Michigan City was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.	K0000	The submission of this plan of correction does not indicate an admission by The Arbors of Michigan City that the findings and allegations contained here in are accurate and true representations of the quality of care and services provided to the residents of The Arbors of Michigan City. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an n economic and efficient manner. The facility here by maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirement governing the management of this facility. It is submitted as a matter of statue only.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The original building (stage I) was constructed in 1972, stage II in 1978 and stage III in 1985. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and resident sleeping rooms. The facility has a capacity of 180 and had a census of 158 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/27/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0021 SS=E	Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 Based on observation and interview, the facility failed to ensure 2 of 20 sets of smoke barrier doors were held open only by devices arranged to automatically close all the doors upon activation of the fire alarm system. This deficient practice affects all residents, staff and visitors on 400 E and 400 W wings. Findings Include: Based on observation at 4:15 p.m. on 07/25/11 with the maintenance supervisor, the two sets of smoke barrier doors, one on 400 E and one on 400 W, did not close after trials	K0021	1. The doors on 400 unit stated in the survey have been adjusted to close according to the regulation.2. All fire doors for the health campus were tested and operating correctly.3. Monthly rounds will be performed by Plant Operations Director or designee during fire drills and doumented.4. Plant Operations Director or desginee will report findings to the QA Committee. The QA Committe will assess findings with recommndatins to resolve issues or continue audit functions for three months.	08/24/2011

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	of operation and activation of the fire alarm system. The maintenance supervisor stated at the time of observation, the doors failed to close due to malfunctioning doors mechanisms and they needed to make the necessary corrections. 3.1-19(b)			
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 1. Based on record review and interview, the facility failed to ensure the generator ran for at least 30 minutes at 30% of the nameplate rating or under operating temperatures for 12 of 12 months. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30	K0144	1. The E Stop was remotely installed on August 10, 2011. The generator test form was revised to reflect the percent of the capacity of the nameplate rating.2. Plant Operations Director or designee conducted a generator test and documented on the revised form.3. Plant Operations Director or designee will conduct monthly generator tests and document on the revised form.4. Plant Operations Director or desginee will report findings to the QA Committee. The QA Committe will assess findings with recommndatins to resolve issues or continue audit functions for three months.	08/24/2011

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	minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating. b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of monthly load test record documentation with the maintenance supervisor at 2:40 p.m. on 07/25/11, monthly logs for the period of July 2010 through July 2011 show the emergency generator was not tested at 30 percent of the capacity of the nameplate rating for the last year. Alternative Energy Solutions who maintains the			

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	emergency generator did not supply documentation of such testing. Based on interview at the time of record review, the maintenance supervisor stated he was not aware of the requirement. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with remote manual stops. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion			

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	Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for the shutting down the engine at the engine and from a remote location. This deficient practice could affect all residents, staff and visitors in the event of an emergency. Findings include: Based on review of the Generator Maintenance records on 07/25/11 at 2:55 p.m. with the maintenance supervisor, there was no documentation available which indicated the horsepower rating of the generator engine provided. Based on interview with the maintenance supervisor during record review, he stated no remote shut off device existed for the generator. The maintenance supervisor indicated the generator was installed before 2003, prior to his hiring. 3.1-19(b)			

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